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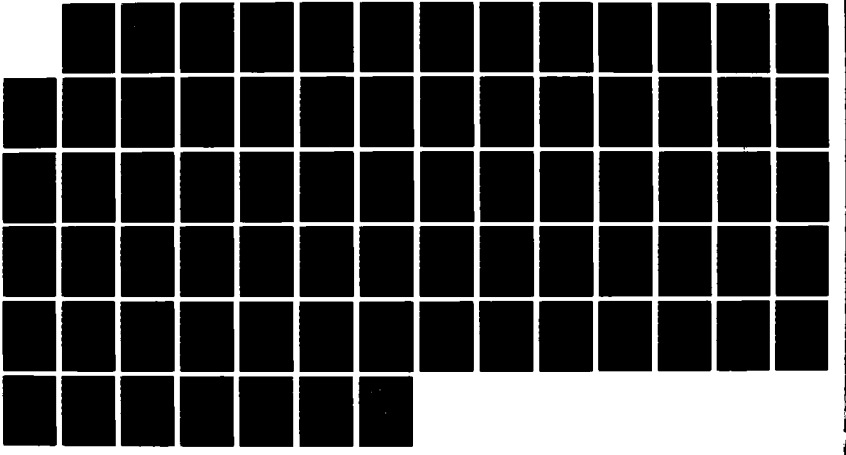

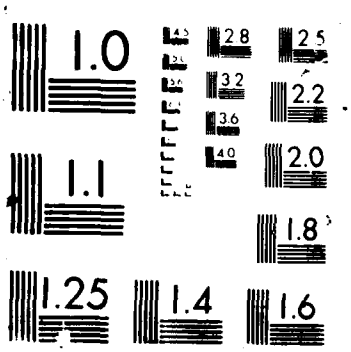
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Naval School of Health Sciences
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Operational Definitions of Ambulatory Care Nursing Activities

Phase II of the Workload Management System for Nursing Ambulatory Care Project

CDR Carolyn S. Warren, NC, USN
LCDR Mabelle K. Sturm, NC, USNR-R
LT David J. Styer, MSC, USN

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This manual identifies, categorizes, and codes common ambulatory care nursing activities in preparation for timing and work measurement. This information will identify activities critical to the determination of nursing and Hospital Corps staffing levels in emergency and outpatient departments of Navy Medical treatment facilities.

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CHAPTER I

THE CODING SYSTEM OF AMBULATORY CARE NURSING ACTIVITIES

The Workload Management System for Nursing (WMSN) is a patient classification/staffing system operational in the inpatient areas of 36 Navy and 50 Army hospitals. The Ambulatory Care Project hopes to extend the WMSN into the emergency and outpatient departments of shore based Naval medical treatment facilities.

In preparation for work measurement studies the operational defining of direct care nursing activities nursing experts were consulted and a literature review was conducted (Calkin, Wallace, Chewning, & Gustafson, 1975; Jenkins & van de Leuv, 1978; Kukuk & Murphy, 1980; Sherrod, Rauch, & Twist, 1981; and Naval Medical Command, 1985). In addition, a survey of 567 registered nurses working in emergency and outpatient departments of Naval medical treatment facilities was conducted in FY 86 (Warren, Styer, & Sturm, 1987). The coding system was developed to simplify identification of activities for timing on laptop computers. The operational definitions are followed by a five or six digit code (S xxxx) or (S xxxx r) which corresponds to the code assigned by Sherrod in the Army WMSN inpatient nursing activity study (See Appendix A).

The four digit code refers to the clinical area (A -Z), the type of activity (1 - 9 plus 0 for Specialty procedures), and the alphabetized list of activites (1-99).

This manual consists of definitions of activities in the following clinical areas studied in FY 87:

Emergency Department	Orthopedic Clinic
Gastroenterology Clinic	Pediatric Clinic
Immunization/Allergy Clinic	Primary Care Clinic (FPC,
Internal Medicine Clinic	MSC, Acute Care)
Obstetrics/Gynecology Clinic	Surgery Clinic (Gen.,Plastic)

Activities found only in specialized areas are defined in the manual under Specialty Procedures. Activities found commonly in several clinical areas are described in ten areas of responsibility:

x100 - Log In/Out	x600 - Instruction/Teaching
x200 - Weights/Measures	x700 - Diagnostic/Tests
x300 - Assessment	x800 - Medications/IV therapy
x400 - Transport/Safety	x900 - Emergency Procedures
x500 - Gen Procedures/Trtmts	x000 - Specialty Procedures

The activities to be timed are listed alphabetically and numbered consecutively under the general area of responsibility: eg., x101, x102, 103.... Observers enter the appropriate clinic letter in place of the "x:"

A000 - Aviation Medicine
B000 - Blood Bank
C000 - Cardiology
D000 - Dermatology
E000 - Emergency Dept
F000 - Gastroenterology
G000 - Hematology/Oncology
H000 - Immunization/Allergy
I000 - Int.Medicine/Endocrin.
J000 - Nephrology
K000 - Neurology
L000 - NP/Alcohol Recovery
M000 - Obstetrics/Gynecology
N000 - Occupational Health
O000 - Ophthalmology
P000 - Oral Surgery
Q000 - Orthopedic
R000 - Otolaryngology
S000 - Pediatric
T000 - Physical Exam Clinic
U000 - PCC/FPC/MSC/MAC
V000 - Pulmonary
W000 - Rheumatology
X000 - Surg.(Gen/Plas/Neuro)
Y000 - Urology
Z000 - Other

Although not explicitly stated, definitions should be understood to incorporate the following:

(1) necessary medications, supplies, or equipment are gathered and calibrated, appropriate preliminary paperwork is accomplished, and hands are washed;

(2) the patient is appropriately screened for privacy and correctly identified;

(3) the person giving the care explains to the patient or significant other what the caregiver is going to do;

(4) the transportation of specimens, chart or the patient is accomplished

(5) equipment is removed (when indicated), the patient care area is straightened, and hands are washed;

(6) observations and procedures are documented.

CHAPTER II

x100 - LOG IN/OUT

CODE

x101 CLINIC LOG-IN PROCESS: confirm appointment time and provider; screen for eligibility; put patient information in clinic log; stamp SF600 and place in chart; give urinalysis chit and supplies to patient with complaint of UTI; place chart with time of appointment and provider's name on it in queue.

x102 DISCHARGE AGAINST MEDICAL ADVICE FROM ER: RN assesses chief complaint; reports to medical officer; provides appropriate information, forms, documentation; assures mental competence of patient prior to release.

x103 DISCHARGE FROM ER: check Emergency Treatment Record (ETR) for completeness (i.e. Doctor's signature, discharge instructions, etc.). Obtain any pertinent handouts (instructions). Explain instructions to patient. Give any necessary equipment or prescriptions. Have patient sign ETR indicating receipt of instructions.

x104 ELIGIBILITY SCREENING: ask patient for outpatient card and ID card, explain how to enter the system if not currently enrolled. Direct patient to appropriate office for initiation of outpatient card and chart.

x105 ER LOG-IN: eligibility screen, triage, history, Vital Signs (VS), documentation; escort patient to exam area; instruct patient; notify appropriate staff.

x106 PATIENT CHECK-OUT PROCESS: stamp all prescriptions and lab chits, give directions to the various areas where tests and studies will be performed, provide instructions (hand-outs) for the tests ordered, make follow-up appointment if indicated; inform where to obtain prescriptions, supplies.

x107 PATIENT TRIAGE/ELIGIBILITY SCREEN: eligibility screening and prioritizing the patient to be seen without appointment according to acuteness of need; includes determination of problem and referral or instructions.

CODE

x108 PATIENT TRIAGE STRETCHER/WHEELCHAIR PATIENT: takes and records chief complaint; vital signs; ascertains medical priority, transfers patient to gurney, moves patient to appropriate area in emergency department, and alerts appropriate personnel.

x109 PREPARATION FOR ADMISSION TO CRITICAL BED: gather all paperwork for patient (flowsheet, emergency treatment record, neuro checks, etc.); call report to unit; obtain portable cardiac monitor, apply leads; obtain portable oxygen and hook up to patient. Obtain any other equipment for transfer. Arrange for ancillary help to escort patient (e.g. corpsmen, nurse, physician, etc.). Inventory clothing, valuables, etc.; enter patient on 24 hour report.

x110 PREPARATION FOR ADMISSION TO NON-CRITICAL BED: gather all paperwork for patient. Gather clothing and valuables, inventory. Call report to ward. Gather any equipment necessary to transfer patient (e.g. portable oxygen). Record entry on unit reports.

x111 PREPARATION FOR PATIENT TRANSFER TO OTHER FACILITY: photocopy all pertinent paperwork to transfer with patient (including lab chits and x-rays). Obtain necessary transfer personnel and equipment. Call to arrange for vehicle to transfer patient. Call receiving facility to give report on patient to receiving nurse. Add patient as entry on ward report.

x112 PRESCRIPTION RENEWAL: obtain patient chart, take V.S. and document; take chart/request to physician or provider; instruct patient; return prescription to patient and assess patient's understanding of therapy; instruct patient as needed.

x113 RECEIVING PATIENT FROM HELICOPTER TRANSFER: appoint ambulance personnel to go out to chopper pad to stand-by for chopper arrival. Accept patient into ER. Call appropriate receiving physician. Check patient into ER, evaluate, and stabilize.

x200 - WEIGHTS/MEASURES

CODE

x201 ABDOMINAL GIRTH MEASUREMENT: expose abdominal area, measure girth (S 0903)

x202 AMBULATORY WEIGHT: balance scales, assist patient onto the scales, read and assist patient off scales (S 0901)

x203 AUTOMATED BLOOD PRESSURE AND PULSE MONITOR: attach cuff to patient; select parameters and record results at intervals ordered or PRN

x204 BLOOD PRESSURE: attach cuff to patient, take blood pressure

x205 BODY LENGTH MEASUREMENT: obtain tape measure, lie baby down, measure length, plot on growth chart (S 2521 r)

X230 BODY MEASUREMENTS (NECK, WAIST, HIPS)

x206 CHEST MEASUREMENT: obtain tape measure, measure chest (S 2520)

x207 EXTREMITY CIRCUMFERENCE MEASUREMENT: place tape measure around the extremity, assess measurement, mark area for future measurement (S 0904)

x208 FETAL HEART TONES, DOPPLER: expose abdominal area, assess fetal heart tones utilizing the doptone with lubricant, clean abdomen (S 2413)

x209 FETAL HEART TONES, MANUAL: position patient in left lateral or semi-recumbent position, find best quadrant for FHT's, place fingers over mother's radial pulse; count fetal heart tones for one minute (S 2412)

x210 HEAD CIRCUMFERENCE: measure head circumference with a tape measure (S 2522)

x211 INFANT HEIGHT/WEIGHT: balance scale, place on proper scale, remove infant clothing and diaper, provide for infant safety while on scale, record results and plot on growth chart (S 2523)

x212 MEASURING AND RECORDING INTAKE: measure or calculate fluids and record amount on Intake and Output Record; wash hands. (S 0208 r)

x213 MEASURING AND RECORDING OUTPUT, DRAINAGE BOTTLES: pour contents from drainage bottle into calibrated cylinder, measure or calculate volume, replace drainage bottle, record amount on Intake and Output Record; wash hands. (S 0304 r)

CODE

x214 MEASURING AND RECORDING OUTPUT, LIQUID FECES/VOMITUS: remove container from patient's bedside; measure liquid in calibrated cylinder, record amount on Intake and Output Record; wash hands. (S 0303 r)

x215 MEASURING AND RECORDING OUTPUT, URINE: - measure or calculate volume with calibrated cylinder, record amount on Intake and Output Record; wash hands. (S 0301)

x216 ORAL TEMPERATURE, PULSE AND RESPIRATIONS: position temperature probe or thermometer, place fingers over radial artery pulse and count rate. Count respiratory rate while fingers are placed over radial artery pulse. Remove fingers from radial pulse rate. Calculate pulse and respiratory rate (S 808)

x217 ORAL TEMPERATURE, PULSE, RESPIRATIONS, & (MANUAL) BLOOD PRESSURE: after positioning temperature probe or thermometer, count respiratory rate while fingers are placed over radial artery pulse. Calculate pulse and respiratory rate (S 0808); place cuff around extremity, position stethoscope, measure blood pressure, remove BP cuff and thermometer when completed. (S 0809)

x218 PEAK FLOW: utilizing a peak flow meter, measure the forced expiratory volume

x219 PULSE - APICAL: expose area, place stethoscope over apex of heart and count rate for one minute, remove stethoscope (S 0803)

x220 PULSE - DOPPLER: place sensor over pulse area, read gauge (S 0810)

x221 PULSE - PEDAL/FEMORAL/POPLITEAL: place fingers on the artery to count rate; calculate rate (S 0809)

x222 PULSE - RADIAL/BRACHIAL: place fingers over artery to count heart rate; calculate rate (S 0802)

x223 RECTAL/AXILLARY TEMPERATURE, APICAL PULSE, AND RESPIRATIONS: position temperature probe, place stethoscope over apex of heart and count rate. Count and calculate respiratory rate. Remove temperature probe, wash hands (S 0811)

x224 RECTAL TEMP/PULSE/RESPIRATIONS/MANUAL BP, ADULT: See x227, x217

x225 RECTAL TEMP/PULSE/RESPIRATIONS/MANUAL BP, PEDIATRIC: See x227, x217

CODE

x226 RESPIRATIONS: Count respiratory rate and or count and calculate rate for 15 - 30 seconds and multiply by four or two (S 0004)

x227 TEMPERATURE - AXILLARY, ELECTRONIC MERCURY: Prepare patient to undress PRN, place temperature probe or thermometer in axillary area, measure temperature, remove temperature probe or thermometer, record (S 0007)

x228 TEMPERATURE - ORAL, ELECTRONIC MERCURY: Place probe or thermometer under tongue, measure temperature, remove probe (S 0005)

x236 TEMPERATURE (ORAL), PULSE, RESPIRATIONS, BP, AMBULATORY WEIGHT

x229 TEMPERATURE - RECTAL ELECTRONIC/ MERCURY: Expose area, insert lubricated temperature probe in anus, measure temperature, remove temperature probe and record results (S 0006)

x237 TEMPERATURE (RECTAL), PULSE, RESPIRATIONS, INFANT WEIGHT

x230 TILTS/ORTHOSTATIC VITAL SIGNS: Place patient in supine position for one minute, take blood pressure and pulse. Place patient in sitting position with feet dangling for one minute and take blood pressure and pulse. Have patient stand (if able) for one minute and take blood pressure and pulse. Record results of measurements. Note if patient symptomatic, report if positive tilts.

x231 VISUAL ACUITY: Instruct and position patient. Test patients vision (each eye) with Snellen chart; record.

x232 WEIGHT, URINE DIPSTICK, AND BP (MANUAL/AUTOMATED): See x202, x204, x729.

x233 WEIGHT (STANDING), HEIGHT, BP (MANUAL/AUTOMATED), PEDIATRIC: See x202, x204

x234 WEIGHT (STANDING), BP (MANUAL/AUTOMATED): See x202, x204

x235 WEIGHT, HEIGHT, ADULT: see x202; measure height.

CODE

x323 ASSESSMENT OF SKIN/HAIR CONDITION/INFECTION:

x302 BOWEL SOUND ASSESSMENT: Use stethoscope to assess status of bowel sounds and record.

x303 CARDIAC ASSESSMENT: Expose area, inspect, palpate, auscultate heart sounds: obtain V.S. record findings.

x304 CLINIC EXIT INTERVIEW: Question patient or responsible adult to ascertain level of understanding of medical problem, follow-up and satisfaction with services provided; ensure patient has all necessary prescriptions, consults, supplies, and follow-up appointment.

x305 CLINIC INTAKE INTERVIEW: (Symptom Related) Obtain reason for reporting to clinic and length of time problem has existed, determine prior history of problem, treatment, and success of treatment. Note risk factors, allergies, and current medications. Isolate patient with communicable disease or refer patient to vital signs station.

x306 CORNEAL EXAM: Anesthetize eye with eye drops, stain with fluorscein, visualize cornea with Wood's lamp; record results. Patch after procedure.

x307 CRYING PATIENT: Approach patient, explore patient's concern, assist in problem solving.

x308 FAMILY ADVOCACY INTERVIEW: interview with service member and/or family; give emotional support and refer appropriately.

x309 FORMALIZED PATIENT CONTACT COMPLAINT: Refer patient to patient contact representative; listen to patient's problem, complaint, suggestion or compliment; write up patient encounter; resolve if possible or refer to next level for review and action as needed; provide emotional support to patient.

x310 GASTROINTESTINAL ASSESSMENT: inspect/auscultate/percuss, palpate, assess abdomen; record findings.

x311 INFANT PULMONARY ASSESSMENT: Assess infant for skin color, respiratory grunting, nasal flaring, respiratory rate, sternal retractions and apnea. Record results.

x312 MENTAL ALERTNESS: make inquiries within the framework of interviewing that will give information about the patient's orientation, memory, intellectual performance, and judgement. (S 1102)

CODE

x313 MOTOR/SENSORY TESTING: assess extremities for sensation awareness and muscle strength (S 1105)

x314 NEUROVASCULAR CHECK: expose area, assess extremity for sensation, swelling, color, warmth, capillary refill, trauma. Compare with other extremity and record results. (S 1611r)

x301 NURSING HISTORY, PROBLEM FOCUSED: interview patient regarding specific health problem (s) (e.g., allergy, substance abuse, gynecologic problem, injury, illness.

x315 NURSING HISTORY (COMPLETE): active listening and questioning of patient/significant other to obtain level of wellness or illness and nursing needs; obtain past medical history, risk factors, allergies, and current medications.

x316 ORIENTATION: question patient regarding mental orientation to time, place, and person (S 1104)

x317 PATIENT/SIGNIFICANT OTHER/SUPPORT: emotional support

x318 PEDIATRIC GROWTH AND DEVELOPMENT ASSESSMENT: give questionnaire to mother/guardian, explain purpose and importance of obtaining accurate information from child, allow parent/guardian appropriate time to complete questionnaire, and answer any questions regarding child's development.

x324 PHYSICAL EXAM, GENITOURINARY SYSTEM: history-taking and non-invasive exam.

x325 PHYSICAL EXAM, MUSCULOSKELETAL: history and non-invasive exam.

x319 PULMONARY ASSESSMENT: initiate assessment by inspection, auscultation of the lungs, and/or percussion of the chest wall over the involved areas; assess symmetry of chest and determine if respiratory movement is abdominal or thoracic; wash hands. (S 1201r)

x320 PUPIL REFLEXES: adjust room lighting, assess pupillary reflexes with a light source (S 1102)

x321 SENSORY DEFICIENT PATIENT SUPPORT: safety and emotional support

x322 VAGINAL BLEEDING ASSESSMENT: determine clinical history of vaginal bleeding; reassure and position patient; expose area, observe and record of amount and type of bleeding.

x400 - TRANSPORT/SAFETY

CODE

x401 ADJUSTING RESTRAINT: replace or apply restraints to upper or lower extremities; wash hands. (S 0500r)

x413 ASSIST TO BATHROOM (ON UNIT):

x402 BODY RESTRAINT APPLICATION: place patient in restraint using self; wash hands.

x403 COMMERCIAL LEATHER RESTRAINT APPLICATION, 2 POINT: test lock/key to restraint; apply to extremities; assess patient response, neurovascular status, and skin integrity Q 15' or more frequently; monitor for airway/safety; wash hands. (S2009 r)

x404 COMMERCIAL LEATHER RESTRAINT APPLICATION, 4 POINT: test lock/key to restraint; apply to extremities; assess patient response, neurovascular status, and skin integrity Q 15' or more frequently; monitor for airway/safety; wash hands. (S2010 r)

x405 PLACING INFANT ON PAPOOSE BOARD: explain reason for restraint to parent, elicit cooperation from infant, place infant on board, secure straps, check to make sure circulation is not impeded. Remove child from board after procedure completed.

x406 SECURING CHILD IN MUMMY DEVICE: using blanket, tuck under child's body, and fold up toward child's neck, secure with pins.

x407 TRANSFER - AMBULANCE STRETCHER TO GURNEY/EXAM TABLE: lock stretcher, grasp sheets or back board, support body, and move to gurney/exam table. Put rails up and secure tubes and/or IVs.

x412 TRANSFER GURNEY/BED TO CHAIR/WHEELCHAIR:

x408 TRANSFER - VEHICLE/CHAIR/TOILET TO WHEELCHAIR: position wheelchair, lock wheelchair, assist patient to wheelchair, and escort to appropriate area.

x409 TRANSFER - STRETCHER TO WHEELCHAIR: position wheelchair and lock, assist patient into wheelchair.

x410 TRANSFER WHEELCHAIR TO STRETCHER: position wheelchair, lock wheelchair and stretcher. Assist patient onto stretcher and secure side rails.

x411 WRIST OR ANKLE RESTRAINT (NON-COMMERCIAL): pad extremity, use clovehitch configuration, secure loops and tie restraint to stretcher; record patient response/neurovascular status and skin integrity Q 15' or more frequently; wash hands.

x500 - GENERAL PROCEDURES/TREATMENTS

CODE

x501 ASSISTING PATIENT WITH RECTAL EXAM: assist patient onto exam table, position patient, set-up specimen container and assist provider with exam, assist patient to sitting position.

x502 COLLECT VALUABLES/PERSONAL EFFECTS: assemble required forms and appropriate number and type of personnel; collect/record valuables and personal effects; secure or carry to designated area.

x503 CONDOM CATHETER APPLICATION: apply condom catheter, connect to drainage bag.(S 1912)

x547 CRUTCHWALKING FITTING/INSTRUCTION:

x504 DEBRIDEMENT, LARGE WOUND: instruct and position patient, cleanse wound, apply dressing.

x505 DEBRIDEMENT, SMALL WOUND: See x505.

x506 DIAPER CHANGE: expose diaper area and cleanse skin: remove soiled diaper and replace with clean diaper; position baby and cover, remove soiled items. (S 2507)

x507 DRESSING CHANGE, LARGE (over 4 x 8 INCHES): remove soiled dressing, cleanse skin, apply dressing using aseptic or sterile technique as ordered. (S 1605 r)

x508 DRESSING CHANGE, SMALL (less than 4 x 8 INCHES): remove soiled dressing, cleanse skin, apply dressing using aseptic or sterile technique as ordered. (S 1604 r)

x510 DRESSING, REINFORCEMENT: apply dressing to present dressing for reinforcement. (S 1606)

x511 DRESSING, WET STERILE: position and prepare patient; using sterile technique, clean wound, using sterile saline to wet inner dressing, place dressing over wound; cover with dry dressing; remove gloves; secure with tape.

x546 ENEMA/FLEETS: prepare, position patient, administer enema.

CODE

x512 FLUID: place plastic drinking tube in liquid, give fluid to patient then remove drinking cup and/or place within reach of patient.

x513 FOLEY CATHETERIZATION: assist patient into lithotomy or dorsal recumbent position. Using aseptic technique, insert catheter, inflate balloon, secure catheter, connect to drainage collection bag; obtain specimens, document observations and procedure. (S 1901 r)

x514 FOLEY CATHETER REMOVAL: expose catheter and drainage system; deflate Foley balloon and remove catheter; measure urine, record. Instruct patient to notify when able to void (for measurement and documentation. (S 1907)

x515 GIVING A BEDPAN: place patient on bedpan, provide toilet tissue, remove patient from bedpan, cover bedpan, and remove from area; wash hands. (S 0305)

x516 GIVING A URINAL: place urinal at patient's bedside, remove cover, assist patient as needed and remove urinal from patient, replace cover; then remove urinal from area; wash hands.

x517 HOT COMPRESS: expose area, apply hot compress and cover site. (S (S 1610)

x518 ICE PACK: expose area, apply ice and cover site. (S 1611)

x519 INCONTINENT CARE: bathe patient and replace linen and chux; remove soiled supplies. (S 0307)

x520 IRRIGATION, EAR - ADULT: gather proper equipment; explain procedure; irrigate ear.

x521 IRRIGATION, EAR - PEDIATRIC: gather proper equipment; explain procedure to parent and child; restrain child as necessary; irrigate ear; comfort child after procedure completed.

x522 IRRIGATION, EYE: prepare eye for irrigation, utilizing IV (saline) and tubing irrigate eye/eye; record. (S 1702)

x523 IRRIGATION, WOUND: prepare patient; using sterile technique irrigate woud; dry site; apply dressing (S 1607 r)

CODE

x524 NASOGASTRIC TUBE - INSERTION: place equipment at bedside, secure towel around patient's neck, give patient glass of water, instruct patient on how to swallow tube, lubricate tube, insert tube, assess for placement, tape in position, then remove equipment from area/or when non-responsive omit glass of water and instructions. (S 1301)

x525 NASOGASTRIC TUBE - IRRIGATION: place irrigation solution at bedside, unclamp or disconnect tube, irrigate tubing with asepto syringe, reclamp or reconnect tubing; record input and output. (S 1302)

x526 NASOGASTRIC LAVAGE (INSERT/IRRIGATE): secure towel around patient's neck, insert stomach tube, assess placement, lavage gastric contents, remove tube, tape, record input and output. (S 1308)

x527 NASOGASTRIC TUBE - REMOVAL: place towel around patient's neck, position patient, remove tape, clamp tube and remove tubing. (S 1303)

x528 OBSERVATION: one on one general standby while patient is in X-ray, awaiting test results or providing safety or psychological support or comfort by continuous observation.

x529 OCCUPIED BED LINEN CHANGE: place linen at bedside; turn patient on side, roll linen to one side and replace; turn patient to other side and complete linen change; remove soiled linen.

x530 PATCH EYE: dress with gauze eye pad; secure dressing and eye shield; instruct patient regarding dressing changes.

x531 POSITIONING/ADJUSTING SIDE RAIL: evaluate patient's need for side rail, change position of side rail up or down depending upon the assessed need. (S 0505r)

x532 POSITIONING FOR X-RAY: assist with positioning patient and X-ray film; assist with removal of exposed film. (S 1422)

x533 POSITIVE LP TAP PATIENT: start IV; administer IV meds as ordered; prepare for admission/transport; provide emotional support for patient and family.

x534 PRECAUTIONS (ISOLATION), GOGGLES, MASK AND/OR GLOVES: observe handwashing, wear goggles (eyeshield), mask and/or gloves as required.

CODE

x534 SKIN CARE: cleanse and dry areas for care. (S 1602 r)

x535 SOAK/REMOVE FROM SOAK, HAND/FOOT: provide patient basin to soak hand or foot; remove and towel dry. (S 1608 r)

x536 STANDBY, PHYSICAL EXAM: assist and position patient as needed, provide intructions; assist with exam as needed.

x537 STANDBY PELVIC: assist patient into lithotomy position. Drape for privacy; assist with procedure as needed (see x723 of diagnostic specimen collection).

x549 STRAIN URINE: provide strainer for urinal or empty urine from bedpan through strainer; collect and label specimen.

x538 SUCTIONING WITH BULB SYRINGE: utilize the bulb syringe to suction the nose and/or mouth. (S 1426)

x539 SURGICAL PREP, LOCAL: prepare skin for prep; shave and cleanse area specified. (S 1613 r)

x540 SUTURE/SKIN CLIP REMOVAL, LESS THAN 15: remove dressing if required; remove sutures or clips; apply steristrips; provide patient instructions. (S 1622 r)

x541 SUTURE/SKIN CLIP REMOVAL, MORE THAN 15: remove dressing if required; remove sutures or clips; apply steristrips; provide patient instructions. (S 1603 r)

x542 SUTURE WOUND, LESS THAN 15 SUTURES: cleanse wound, prepare and position patient; assist with or suture wound using sterile technique; dress wound; record procedure/observations; provide patient follow up instructions.

x543 SUTURE WOUND, MORE THAN 15 SUTURES: See x542

x544 UNDRESS PATIENT/REMOVE CLOTHING: position patient, remove clothing and place clothing in bag or under gurney per unit policy.

x545 WARM SOAK: (to ear, skin, joint or muscle area) - 20', apply warm pack, observe, wash hands.

x550 WOUND, REPACK: using sterile technique, unpack and repack gauze in wound, apply dressing.

x600 - INSTRUCTION/EDUCATION

CODE

x601 ANSWER PATIENT QUESTION: time spent in answering questions for patient or patient's parent/guardian. (S 0700 r)

x602 EXPLANATION OF PROCEDURES/TEST OR WITNESS CONSENT: instruct patient on what to expect, why test is to be done, and what personnel will do during the test. (S 0702)

x621 POST-OP INSTRUCTION:

x603 TEACHING BLOWBOTTLES/INCENTIVE SPIROMETER: instruct patient on the purpose and use of equipment. (S 2305)

x604 TEACHING CHEMOTHERAPY INSTRUCTION: provide instructions on dosage, drug action, adverse effects, signs and symptoms which require medical evaluation. (S 2310)

x605 TEACHING COLOSTOMY CARE: provide instructions on the purpose, equipment and technique of colostomy irrigation and colostomy bag care. (S 2302)

x606 TEACHING - DIABETIC: provide information on the disease process and care related to this process (signs and symptoms on insulin lack/overdosage, foot care, rotation of injection sites, exercise program, storage of medication, and maintenance of equipment). (S 2313)

x607 TEACHING, DIAGNOSTIC TEST: provide information on the purpose and requirements for the diagnostic test. (S 2308)

x608 TEACHING, DIET/NUTRITION EXPLANATION: provide instruction on dietary requirements/restrictions for purposes of weight control program , health maintenance, or specific medical condition. (S 2307)

x609 TEACHING, DISEASE/CONDITION RELATED: provide instruction on the nature and scope of the disease process, special care requirements, limitations and/or restrictions related to disease illness. (S 2309)

x610 TEACHING, DRESSING CHANGE: provide instruction on technique of dressing change, skin care and how to recognize abnormal conditions related to disease/injury; and who to report complication to. (S 2311)

CODE

x612 TEACHING, INSULIN ADMINISTRATION: provide information on dosage, types of insulin, syringe utilization technique, care of equipment, rotation of sites, and specific drug-related information. (S 2312)

x613 TEACHING, PHYSICAL FITNESS INSTRUCTIONS: provide information on military physical fitness instructions.

x614 TEACHING, POSTURAL DRAINAGE: provide instruction on the purpose and technique for postural drainage. (S 2303)

x615 TEACHING, PREOPERATIVE INSTRUCTION: provide instruction on preoperative and postoperative requirements (skin preparation, cough and deep breathe, ankle exercise/position change). (S 2307)

x616 TEACHING, SELF-MEDICATION ADMINISTRATION: provide patient or responsible adult instruction on dosage, route and specific drug related information. (S 2301 r)

x617 TEACHING, URINE CLEAN CATCH: provide instructions on the purpose and technique for clean catch urine.

x618 TEACHING, URINE TESTING: provide instructions on the purpose and technique for urine testing. (S 2304)

x619 UPDATING FAMILY/PATIENT ON CONDITION: time spent communicating with patient or family on condition.

x620 VISITING WITH PATIENT/PURPOSEFUL INTERACTION: time spent with a patient without providing any direct physical care and which is not a response to a question. (S 0704)

x700 - DIAGNOSTIC TESTS

CODE

x701 ARTERIAL PUNCTURE - BLOOD GASES: expose area, cleanse site, perform arterial puncture; withdraw blood sample, plug needle; apply pressure to puncture site approximately 10 minutes. (S 1502)

x702 BLOOD SAMPLE, DEXTROSTIX: cleanse site, puncture site with lancet, obtain sample, apply pressure over site, process sample and read results. (S 2531 r)

x740 BREATHALYZER

x703 BLOOD SAMPLE, LANCET - EAR/FINGER/HEEL: cleanse site, puncture site with lancet, obtain sample, apply pressure over site, prepare specimen for lab. (S 2530 r)

x704 CARDIAC MONITORING: attach patient to monitor, turn on, and observe monitor and/or monitor strips as required.

x705 CULTURE, NOSE: position patient, obtain nose culture, label. (S 1708)

x706 CULTURE, SPUTUM: position patient, have patient cough to obtain sputum; label specimen. (S 1710)

x707 CULTURE, THROAT: position patient, obtain throat culture, label. (S 1709)

x735 CULTURE, WOUND: position patient, obtain culture, label.

x708 ECG, CAPOC: set up machine, position patient, expose area, attach leads, and perform ECG. Review ECG and report to physician.

x709 ECG, CAPOC LINK WITH MODEM TO CENTRAL ECG READING SITE: see x708

x720 ECG, RHYTHM STRIP-MONITOR: obtain 20 second strip, label with patient name, date, and time and attach to chart. (S 1002)

x710 ECG, 12 LEAD : position patient, expose area, attach leads, and perform ECG. Review ECG and report to physician. (S 1003 r)

x711 FECAL SAMPLE COLLECTION: upon obtaining a feces sample, place sample in collection container, label and remove from area. (S 2210)

CODE

x712 HEMATOCRIT: upon obtaining the blood sample, process, assess, record the results. (S 2211)

x713 HEMOCCULT OR/GUAIAC TESTING, FECES/VOMITUS/GI DRAINAGE: upon obtaining sample, test sample for occult blood, record results. (S 2209)

x737 HOLTER MONITOR APPLICATION: instruct patient and apply portable telecardiography monitor.

x741 HOLTER PUMP APPLICATION: instruct patient; apply infusion devision for IV or medication,

x714 LEGAL ALCOHOL/DRUG SCREEN: obtain written consent, gather supplies/equipment/appropriate form, notify appropriate authorities; obtain specimen with chain of custody; wash hands; carry specimens to specific laboratory area for disposition.

x715 LUMBAR PUNCTURE: obtain consent; assist with procedure; observe and record neurological status, puncture site, patient response; V.S. Q 15' till stable; instruct patient on positioning (flat); send laboratory specimens as ordered; wash hands. (S 2202 r)

x716 MONITOR LEADS APPLICATION/EXCHANGE: prepare patient (shave hair if necessary), exchange/or apply new leads. (S 1001)

x717 PATHOLOGY SPECIMENS: place specimens in proper containers and label. Fill out appropriate chits and send to appropriate area in laboratory.

x718 PKU HEEL STICKS: place equipment by patient, expose heel, cleanse skin, use lancet to puncture heel, smear blood from heel on three circles of PKU card, label specimen, remove equipment and clean area. Record patient's name and record number in log. Mail to Dept. of Health and Mental Hygiene.

x719 PREGNANCY TEST: fill out lab chits for urine or serum pregnancy tests, (as appropriate) and direct patient to laboratory to provide appropriate specimen.

x721 SCHOOL PHYSICAL EXAM LAB WORK: obtain outpatient card from parent or guardian. Make out chits for CBC and/or routine urine. Explain to parent and child procedure for obtaining urine sample and provide with materials. Label urine sample and direct parent and child to lab for blood drawing. Diect to immunization clinic for updating immunizations.

CODE

x722 SEPTIC WORK UP PROTOCOL: obtain outpatient card, prepare lab chits; obtain signed consent form for lumbar puncture; witness permit if necessary. Assist physician by restraining child during L.P. procedure and blood culture drawing. Obtain urine for u/a and culture. Send all lab work to stat lab. Provide emotional support for parent and/or child.

x723 STAND-BY FOR PELVIC EXAMINATION/COLLECTION OF VAGINAL SPECIMENS: help patient undress if necessary, position patient, prepare slides (for KOH, NS), get clamydia slide and prepare as needed get GC plates as needed; get PAP slides if needed; assist provider with exam. Provide emotional support for patient.

x724 STRAIGHT CATHETERIZATION: same procedure as for Foley insertion. Instead of inflating balloon, empty bladder, obtain specimen, remove catheter, document output and procedure.

x725 THEYER-MARTIN CULTURES, MALE: (gonorrhea) obtain urethral smear/gram stain slide with sterile cotton swab and plant on culture plates.

x738 TREADMILL (STRESS TEST): witness consent, instruct patient; apply leads, monitor during prescribed activity.

x726 URINE COLLECTION BAG - APPLICATION: place equipment by patient expose area cleanse area, apply urine collection bag, cover baby for warmth. (S 2508 r)

x727 URINE COLLECTION BAG - REMOVAL: position child, expose area, carefully peel bag off, pour urine into clean test tube or sterile cup, label.

x728 URINE DIP AND SPIN: obtain urine sample from patient; pour into clean test tube; dip reagent strip (multistix with SG) into urine; read for specific gravity, pH, protein, glucose, ketone, etc.; put test tube in centrifuge; spin 5 minutes; label and put in rack for physician to prepare slides.

x729 URINE DIP/CHEMSTRIP: obtain fresh urine sample. Dip reagent strip into urine and observe color change to detect presence of protein or sugar.

x730 URINE SPECIFIC GRAVITY (INDEX REFRACTOMETER): collect fresh urine sample from patient, place drop of urine on the glass section beneath the glass cover, read the refractometer, record. (S 2206 r)

CODE

x731 URINE SPECIFIC GRAVITY (URINOMETER): collect fresh urine sample from patient, pour into clean cyclinder, float urinometer in specimen, read, and record. (S 2206 r)

x736 URINE SPECIMEN COLLECTION (ROUTINE), ASSIST:

x732 VENIPUNCTURE - BLOOD CULTURE: expose area, apply tourniquet to extremity, cleanse site, perform venipuncture, withdraw blood sample, inject blood into bottles, apply pressure to puncture site. (S 1502 r)

x733 VENIPUNCTURE - BLOOD SAMPLES: expose area, apply tourniquet to extremity, cleanse site, perform venipuncture and withdraw blood sample, and then apply pressure to puncture to puncture site. Label blood tubes. (S 1501)

x734 VENIPUNCTURE - PEDIATRIC: stamp proper lab chits; position patient; restrain child as necessary; expose area; apply a tourniquet to extremity; cleanse site; perform venipuncture; comfort child. Requires 2:1 staff for restraining and performing procedure.

x739 RAPID THROAT CULTURE TEST:

x800 - MEDICATIONS/IV THERAPY

CODE

x801 ASSIST WITH IV INSERTION - SMALL CHILD: set up equipment including infusion pump, explain procedure to parent and child, determine if parent should remain with child, position child and restrain as necessary, assist provider, provide emotional support for child.

x802 ASSISTING AND MONITORING CHILD RECEIVING BLOOD PRODUCTS: obtain correct transfusion; verify with provider correctness of information on transfusion; take vital signs; assist provider in connecting blood unit to present IV system. Observe for potential allergic reaction; vital signs Q 15 minutes during procedure; monitor 1:1 during procedure.

x803 ASSISTING AND MONITORING CHILD RECEIVING IM CHEMOTHERAPY: position patient in treatment room; vital signs taken; ice applied to thigh for 10 minutes prior to injection; assist physician with injection by restraining child; vital signs Q 15 minutes x 2 post injection. Record procedure and any reaction, monitor 1:1 during procedure.

x804 ASSISTING AND MONITORING CHILD RECEIVING INTRATHECAL MEDICATION: prepare LP tray and have gloves ready; have medication near-by; obtain patient's vital signs; prepare and position patient, holding patient to maintain proper LP position. Close supervision of patient for 1 hour with vital signs Q 15 minutes x 1 hr post-procedure. Prepare culture and chemistry chits. Ensure specimens transported to lab.

x805 EYE CARE: cleanse eyes and apply solution/ointment as prescribed; apply eye patch. (S 1701)

x806 INSTILLATION OF DROPS, EAR: position patient, instill drops into ear(s). (S 1706)

x807 INSTILLATION OF DROPS, EYE: position patient, instill drops into eye(s). (S 1705)

x808 INSTILLATION OF DROPS, NOSE: position patient, instill nose drops. (S 1701)

x809 INTRA-MUSCULAR, NARCOTIC: locate site of injection, administer medication; observe patient response.

CODE

x810 INTRA-MUSCULAR, NON-NARCOTIC: locate site for injection, administer medication; observe patient response. (S 2102)

x830 INTRATHECAL MED:

x811 INTRAVENOUS INFUSION - BLOOD OR BLOOD PRODUCTS: assure correct patient and correct transfusion per unit policy. Connect transfusion to present intravenous system, adjust rate, and record on I and O sheet. (S 1514)

x812 INTRAVENOUS INFUSION - CHANGE IV BAG/BOTTLE: remove used IV; hand new IV and adjust flow rate (S 1506r)

x829 INTRAVENOUS INFUSION - CHECK/FIX:

x813 INTRAVENOUS INFUSION - FLOW RATE: calculate and adjust flow rate as ordered. (S 1504)

x814 INTRAVENOUS INFUSION - INFUSION PUMP SET-UP: set up IV and flush system, connect to IV pump, adjust flow rate dial, begin infusion, and record on I and O sheet. (S 1511 r)

x815 INTRAVENOUS INFUSION - INITIATING: expose area. Apply tourniquet to extremity, cleanse site, perform venipuncture and connect IV tubing, remove tourniquet and dress puncture site, secure IV tubing with tape. Calculate and regulate flow rate, and record on Intake and Output record. (S 1505)

x816 INTRAVENOUS INFUSION - IV PUSH MEDICATION: select and cleanse IV injection site with alcohol prep, inject IV medication as ordered, and record. (S 1507)

x817 INTRAVENOUS INFUSION - PIGGYBACK MEDICATION: connect piggyback infusion to existing IV line, adjust rate as ordered, and record on chart. (S 1509 R)

x818 INTRAVENOUS INSERTION/SCALP VEIN: hold and/or restrain child, prepare site, palpate vessel to be certain it is not an artery, insert 23 or 21 gauge butterfly, tape securely, connect to intravenous solution; set up on infusion pump to prevent fluid overload; monitor infusion; recording fluid intake and output.

CODE

x819 INTRAVENOUS LINE - TERMINATION: remove dressing and terminate IV, apply pressure to site, and dress PRN; record on I and O sheet. (S 1510)

x820 NEBULIZER TREATMENT, ADULT: record V.S. prior to treatment; prepare medication and add to nebulizer with diluent; instruct patient and assure proper breathing pattern; record V.S. Q 5 minutes and stay with patient until treatment is completed. (S1427 r)

x821 NEBULIZER TREATMENT, PEDIATRIC: record V.S. prior to treatment; prepare medication and add to nebulizer with diluent; instruct patient and assure proper breathing pattern; record V.S. Q 5 minutes and stay with patient until treatment is completed. (S1427 r)

x822 ORAL OR PER NG TUBE: obtain a glass of water and administer the oral medication or instill medication and water per NG. (S2101r)

x823 SUBCUTANEOUS: locate site for injection, administer medication; (S 2103)

x824 SUBCUTANEOUS INFILTRATION BY XYLOCAINE: prepare patient, inject medication; observe for anesthesia.

x825 SUBLINGUAL: place medication under patient's tongue. (S 2106)

x826 SUPPOSITORY, RECTAL/VAGINAL: prepare and administer suppository wearing glove or finger cot. (S 2104 r)

x82c THROAT SPRAY:

x827 TOPICAL: expose skin or mucosa site for topical application of medication, apply medication wearing gloves. (S2105 r)

x900 - EMERGENCY PROCEDURES

CODE

x901 AIRWAY INSERTION: insert airway, assess patency of airway; assess respirations.

x902 CARDIOPULMONARY RESUSCITATION: perform necessary procedure of cardiopulmonary resuscitation.

x903 NOSEBLEED MANAGEMENT: position patient facing the nurse, instruct patient to tilt head slightly forward, pinching the soft lobular portion of the patient's nose for a few minutes.

x904 RESPIRATORY RESUSCITATION, AMBU: perform pulmonary resuscitation with ambu. (S 1416 r)

x905 SEIZURE CARE: lie the patient down, loosen clothing around neck, turn head to side, place folded blanket under head to prevent trauma if patient is on hard surface; call for equipment to suction and administer 02 if necessary, obtain V.S., assess post-ictal phase. (S 180 r)

CHAPTER III
xOOO - SPECIAL PROCEDURES/PROTOCOLS

The activities to be timed are listed alphabetically and sequentially numbered under the general area of responsibility: e.g., x101, x102, x103.... The first digit of the code for activities will be a letter signifying the clinical area in which the activity is performed. These codes will be as follows:

AOOO - Aviation Medicine
BOOO - Blood Bank
COOO - Cardiology
DOOO - Dermatology
EOOO - Emergency Dept
FOOO - Gastroenterology
GOOO - Hematology/Oncology
HOOO - Immunization/Allergy
IOOO - Internal Medicine/Endocrin.
JOOO - Nephrology
KOOO - Neurology
LOOO - Neuropsychiatric/Alc.Recovery
MOOO - Obstetrics/Gynecology
NOOO - Occupational Health
OOOO - Ophthalmology
POOO - Oral Surgery
QOOO - Orthopedic
ROOO - Otolaryngology
SOOO - Pediatric
TOOO - Physical Exam Clinic
UOOO - Primary Care/FPC/MSC/MAC
VOOO - Pulmonary
WOOO - Rheumatology
XOOO - Surgery(Gen/Plast/Neuro)
YOOO - Urology
ZOOO - Other

Highly specialized procedures are defined separately under its specified clinical area. In FY 87 these areas concluded Emergency Department, Gastroenterology, Immunization/Allergy Clinic; Obstetrics/Gynecology, Orthopedic, Pediatric, and Surgical Clinic.

The Emergency Department procedures have been organized into the following categories:

ER, General:	E001 - E007
ER, Cardiac:	E008 - E018
ER, GYN:	E019 - E021
ER, NP:	E022
ER, Pulmonary:	E023 - E040
ER, Trauma:	E041 - E050

CODE

E001 BODY TEMPERATURE REGULATION, HYPOTHERMIA: apply local heat to torso, cover with blankets, administer warmed fluids P.O. of IV as ordered; administer heated 02 as ordered; monitor V.S. and rectal temperature; monitor patient's mental status; document patient's response to therapy.

E002 DEATH CARE: prepare patient and apropriate identification and documents; cover with shroud; inventory valuables and clothing; complete SL/VSL chit and notify morgue prior to transport of body. (S 1621 r)

E003 FOWLERS/TRENDELENBURG POSITION: position patient (bed/gurney) in Fowlers or trendelenburg position; assess comfort and condition of patient. (S 0507)

E004 ISOLATION, GOWNING AND GLOVING: upon arrival at isolation area, wash hands, put on gown, mask, and gloves, or when departing the isolation area, remove isolation gown, discard mask and gloves; wash hands. (S 1620)

E005 RING CUTTING: obtain written consent; prepare patient, cut ring; assure safety of valuables.

E006 SEIZURE PRECAUTIONS: ascertain if patient is at high risk for seizure, pad railings on gurney/bed, keep siderails up at all times, have padded tongue blade or airway available: suction and 02 nearby.

E007 THERMAL BLANKET: place patient supine on blanket; set water temperature control for heating or cooling as appropriate and plug in; monitor rectal temperature and record as ordered.

CODE

E008 ADJUSTING CARDIAC MONITOR/CONNECTION LEADS/RESET ALARM: adjust cardiac monitor, connect leads and reset the alarm. (S 1012)

E009 CARDIOVERSION/DEFIBRILLATION: set defibrillator on prescribed energy level, assess V.S.; perform or assist physician with procedure; repeat V.S.; assess patient response. (S 1523 r)

E010 CENTRAL VENOUS LINE PLACEMENT: position patient, assist with procedure and record patient response.

E011 EXTERNAL PACEMAKER: place patient on cardiac monitor; assess V.S.; assist physician with procedure; repeat V.S. and record patient response. (S 1521)

E012 HICKMAN/BROVIAC CATHETER (CENTRAL VENOUS ACCESS): position patient, expose area, use clean technique and sterile equipment per unit policy to obtain specimen or administer medications or fluids; flush external catheter as specified.

E013 INTRAVENOUS CUTDOWN: prep site, assist physician with procedure, connect IV line; assess patency of IV, adjust flow rate; assess neurovascular status of extremity; assist with suture; apply dressing. (S 1529 r)

E014 MAST SUIT APPLICATION/REMOVAL: lay out mast suit and foot pump, check inflation; place patient supine in mast suit; attach trouser legs; assess patient's V.S.; begin inflating one leg at a time in small increments of mmHg, per policy or physician order; assess BP and pulse after each inflation; inflate abdominal section if indicated; assess and record patient's response to the therapy. Removal: deflate abdomen or one leg at a time in small increments per policy or physician order; check V.S.; assess and record patient response.

E015 MEDIPORT (CENTRAL VENOUS ACCESS): position patient, expose area using sterile technique, cleanse site, and obtain 3 cc of blood and discard; draw blood/start infusion/administer medication as necessary and flush subcutaneous catheter with saline then heparin per policy and record.

CODE

E016 RHYTHM STRIP MEASUREMENT: obtain rhythm strip, measure P-R interval, S-T segment, and assess for arrhythmic pattern. (S 1009)

E017 ROTATING TOURNIQUETS, AUTOMATED: attach cuffs to extremities as specified, set machine pressure, and rotation cycle for every 15 minutes; monitor neurovascular status of extremities and cardiovascular status of patient per unit policy.

E018 ROTATING TOURNIQUETS, MANUAL: attach tourniquets to extremities as specified and rotate tourniquets every 15 minutes; monitor neurovascular status of extremities and patient's cardiovascular status per unit policy and record patient's response to treatment.

CODE

E019 CULDOCENTESIS: obtain written consent; prepare and position patient for pelvic; assist with prodedure; monitor and record patient response and V.S.

E020 EMERGENCY DELIVERY: reassure and position patient in lithotomy position; open precipitate delivery pack; assist with delivery as necessary; support baby, suction with bulb syringe as needed; assess APGAR of baby 1 and 5 minutes; assess status of mother and support as needed; obtain lab specimens; record observations; monitor mother post-partum until transfer; ensure wamth of baby and transfer to nursery.

E021 SEXUAL ASSAULT PROTOCOL TO COLLECT LEGAL SPECIMENS: triage patient; fill out ETR: obtain V.S. contact appropriate authorities; complete rape kit information; position patient in lithotomy position, provide female support person, assess injuries and history; document and report observations; obtain consent for legal evidence collection and photographs if indicated; assist in exam, specimen collection; bag clothing, assess patient's safety needs in transportation and home environment/shelter or admit to hospital; give medication as directed; refer to Rape Crisis community organization.

CODE

E022 SUICIDE PRECAUTIONS: restrict patient to ensure safety from self-harm; witness interactions; remove potentially dangerous objects/equipment/supplies; search patient; watch patient swallow medications if any ordered; provide constant supervision and therapeutic support; record at frequent intervals.

CODE

E023 CHEST PULMONARY THERAPY WITH POSTURAL DRAINAGE: position patient; initiate treatment by ausculation of lung fields; perform percussion to each involved segment followed by vibration; wash hands. (S 1409)

E024 CHEST TUBE, INSERTION: obtain written consent from patient or guardian, assist physician with insertion of chest tube, prepare water-sealed drainage system, tape all connections and drainage bottles, assess breath sounds; wash hands; assure X-ray post-insertion (S 1428 r)

E025 CHEST TUBE, REMOVAL: assist physician with removal of chest tube, apply pressure dressing, assist with X-ray of patient; assess patient breath sounds, monitor vital signs. (S 1429 r)

E026 COUGH AND DEEP BREATHE: have patient cough and deep breathe; reposition patient to expand all lobes; dispose of sputum. (S 1419)

E027 EXTUBATION: assist physician with removal of endotracheal tube; check breath sounds. (S 1430)

E028 INCENTIVE SPIROMETER: instruct patient how to use the spirometer and assist patient during the procedure to determine understanding. (S 1420 r)

E029 INTUBATION - assist physician during the intubation process, tape endotracheal tube in place; check for air movement in lungs. (S 1421)

E030 OXYGEN ADMINISTRATION, MASK: turn on oxygen, fit the mask over the mouth and nose, adjust headband, evaluate fit and patient's adjustment to the equipment, and regulate oxygen flow rate. (S 1402)

E031 OXYGEN ADMINISTRATION, PRONGS: fit nasal prongs and adjust headband, regulate oxygen rate; evaluate patient's adjustment to oxygen and equipment. (S 1403)

E032 RESPIRATORY RESUSCITATION, RESPIRATOR: check all equipment, assist physician with insertion of endotracheal tube, check for placement of tube, tape tube in place, bag breathe, connect to respirator; (S 1416 r)

CODE

E033 SUCTIONING, ENDOTRACHEAL: put on sterile gloves, suction through endotracheal tube, flush catheter before and after each use, bag breathe between each aspiration, remove gloves (S 1414)

E034 SUCTIONING, NASO-TRACHEAL: put on sterile gloves, pass nasal catheter and suction, flush catheter before and after each aspiration; remove gloves (S 1413)

E035 SUCTIONING, ORAL: suction oral cavity with suction catheter/oral suction tip, flush catheter before and after each aspiration; wash hands (S 1411)

E036 SUCTIONING, TRACHEOSTOMY: put on sterile gloves, suction and flush catheter before and after each aspiration; remove gloves (S 1412)

E037 TRACHEOSTOMY, CHANGING TUBE: untie tracheostomy strings, remove and replace tracheostomy tube, cleanse skin, tie tracheostomy strings; wash hands (S 1405)

E038 TRACHEOSTOMY, CLEANING CANNULA: put on sterile gloves; complete tracheostomy suction, remove, clean and replace inner tube; remove gloves (S 1408)

E039 TRACHEOSTOMY, DRESSING CHANGE: remove soiled dressing, cleanse skin, replace dry dressing, change tracheostomy ties as indicated; wash hands (S 1423)

E040 THORACENTESIS: Obtain written consent of patient or legal guardian, obtain vital signs, assist physician and support patient during the procedure, repeat vital signs, measure and record aspiration fluids; send specimen to lab as ordered; wash hands (S 1417 r)

CODE

E041 CHILD ABUSE: triage patient; fill out emergency treatment record; obtain V.S.; provide physical and psychological support for child; complete abuse form; notify pediatrics and social worker watch; obtain photographs when indicated; notify Admin Duty Officer and Security if incident took place on base; obtain X-rays when indicated; assess for need to admit child to hospital or provide shelter.

E042 DEBRIDEMENT (BURN) PROCEDURE: prepare and position patient; remove old dressing with wound and skin precautions, assist with or carry out procedure; apply dressing; administer medications as ordered, record and report observations to physician.

E043 DECUBITUS CARE: cleanse skin, apply heat lamp and/or expose to light; administer medication as prescribed; document size (e.g., by placing exposed X-ray film over site, mark outline and date. (S 1601 r)

E044 EXTREMITY SOFT TISSUE INJURY CARE: triage patient; fill out emergency treatment record; elevate and/or immobilize extremity; apply ice to injury if less than 24 hours old; assess pulse distal to injury and record on ETR and/or flowsheet; bring patient to X-ray; ace wrap or cast (in ortho) applied with sling or crutches as needed; provide discharge instructions for follow-up care.

E045 FOREIGN BODY REMOVAL: prepare patient; assist or carry out procedure; cleanse and dress wound.

E051 GLASGOW COMA SCALE: evaluate visual, verbal, and motor response to external command or painful stimulus according to a graded scale.

E046 HEAD/NECK TRAUMA PROTOCOL: triage patient; fill out emergency treatment record; provide safety and stability in transporting patient to exam room and assist with undressing; assess neurological status, V.S., and document; place cervical/Philly collar; start nursing flowsheet; obtain bloodwork, UA and ETOH level as ordered; provide head injury instruction.

E047 INCISION AND DRAINAGE SMALL ABSCESS: obtain consent, anesthetize patient, incise, drain and pack subcutaneous abscess; dress site; instruct patient.

CODE

E048 NEEDLESTICK PROTOCOL: triage patient; fill out emergency treatment record; assess wound; soak and/or scrub wound with antiseptic/saline solution; complete incident report; draw 2 red top tubes from patient and send to lab with 2 red top tubes that were drawn from source of contaminated needle; instruct patient in follow up with physician (Infectious Disease); 2 cc ISG IM given to patient; provide discharge instructions.

E049 SPOUSE ABUSE: triage patient; fill out ETR; obtain V.S.; support patient's physical and psychological needs; complete abuse form; notify Admin Duty Officer and Security if incident took place on base; notify duty social worker; obtain photographs when indicated; obtain X-rays if necessary; locate safe house/shelter when indicated; assess need to admit; notify civilian authorities if patient received gunshot wound or knife wound.

E050 SUBUNGAL HEMATOMA RELEASE: soak patient's nail/digit in antiseptic solution; with appropriate instrument burn hole in nail to relieve pressure of hematoma; drain and dress.

F000 - GASTROENTEROLOGY

CODE

F001 COLONOSCOPY: Vital sign assessment; start IV; pre-procedure teaching; witness permit; prepare meds, assemble equipment & supplies; check equipment; position patient; assist with procedure; collect & label specimens; monitor patient 1:1 during procedure, documentantion; assist patient into wheelchair; transport to recovery room; clean equipment; monitor sedated patient (VS on arrival and Q 30 min until awake; give discharge instructions. (S 1306) See x001.

F002 COLOSTOMY DRESSING CHANGE: Place equipment at bedside, remove soiled dressing, cleanse skin and stoma, apply clean dressing, and then remove equipment from area. (S 1307)

F003 COLOSTOMY IRRIGATION: Place equipment at bedside, remove colostomy bag/dressing, administer irrigation solution, allow for return of fluid and feces, cleanse skin and stoma, reapply colostomy bag/dressing; then remove equipment from area. (S 1306)

F004 DIAGNOSTIC LAPAROSCOPY: witness consent; 2 or 3 nursing staff attending patient & physican; instruction & pre-op work-up & emotional support; abdominal prep patient; ensure sterile field; EKG monitor; IV medication; specimen collection & preparation.

F005 ENDOSCOPY: witness consent; assess baseline vital signs (T.P.R., BP) IV sedation monitor 1:1 during & after the procedure, repeat vital signs, provide instructions; collect & label specimens.(S 1313) (see X005)

F006 ENEMA - CLEANSING: position patient administer solution; record results. (S 1304 r)

F007 ERCP - ENDOSCOPIC RETROGRADE CHOLEANGIO PANCREATOGRAPH: witness consent; prepare patient; endoscopy/fluoroscopy procedure IV medication; monitor patient during and 4-6 hrs post-procedure.

F008 ERCP WITH SPHINCTEROTOMY: See F007.

F009 FECAL IMPACTION ASSESSMENT/REMOVAL: Position patient, put on rubber gloves, assess for fecal impaction and then manually break up fecal mass (S 1312)

F010 ILEOSTOMY/ILEOCONDUIT - DRESSING CHANGE: remove ileostomy bag or dressing, cleanse skin and stoma area, replace ileostomy bag or dressing. (S 1310)

CODE

F011 LIVER BIOPSY: witness consent; instruct patient to undress; monitor V.S.; check biopsy site; ensure sterile procedure; assess pain level; monitor post-procedure 4-6 hours VS Q 15' x 4, Q 30' x 2, Q 1 hr until stable.

F012 NASOGASTIC TUBE - INSTILLATION: place medication, and/or normal saline at bedside, unclamp or disconnect tube, instill solution with asepto syringe, reclamp or reconnect tubing. (S 1311)

F013 PARACENTESIS: measure vital signs, prepare patient and tray for procedure, support patient during the procedcre, measure vital signs obtain a written consent before the procedure; send specimens to lab as requested. (S 1309 r)

F014 PERCUTANEOUS ENDOSCOPIC GASTROSTOMY(PEG): assess baseline V.S. assure sterile field procedure; support patient during procedure; repeat V.S.

F015 SIGMOIDOSCOPY/PROCTOSCOPY: pre-procedure instructions; fleets enema; prepare biopsy specimen as needed.

H000 - IMMUNIZATION/ALLERGY

CODE

H001 ACTIVE DUTY IMMUNIZATION SCREENING: obtain medical record and immunization record from patient; note date of last booster, administer any needed immunizations or schedule time when they may be obtained; instruct patient of future immunization needs.

H002 ALLERGY INJECTION: screen instruction sheet and allergy record; question patient on prior reaction, prepare skin; administer injection; observe for potential reaction; record site; instruct patient on observation time to be checked.

H003 ALLERGY SKIN TESTING: chart review; prepare allergen tray, assist patient to proper position for testing; explain testing procedure; prepare skin; introduce allergens, observe for potential anaphylaxis; record results.

H004 ANERGEN SKIN TESTING: sames an H003 except anergens.

H005 IMMUNIZATION INJECTION: screen immunization record for current need; question patient for prior reactions to immunizations or current acute febrile illness; obtain signed consent; prepare skin area; administer injection; instruct patient or guardian; record in chart and individual immunization record;

H006 IMMUNIZATION, INJECTION AND ORAL: screen immunization record for current need; question patient for prior reactions to immunization or current febrile illness; obtain signed consent; administer oral medication; instruct patient or guardian that patient is to be NPO for 20 minutes; record in chart and individual immunization record.

H007 IMMUNIZATION, ORAL: screen immunization record for current need; question patient for prior reactions to immunization or current febrile illness; obtain signed consent; administer oral medication; instruct patient or guardian that patient is to be NPO for 20 minutes; record in chart and individual immunization record.

H008 IMMUNIZATION CONSENT FORM TEACHING: give information sheet with consent form to patient or guardian for all immunizations to be given; allow time for reading of material and answer questions; obtain signature.

H009 INHALERS: obtain medication for patient; screen for possible allergic reaction; explain use and possible side effects; have patient self-administer medication; note any reaction.

CODE

H013 INSTRUCTION REGARDING IMMUNIZATION SIDE EFFECTS: explain normal reaction to immunizations: abnormal reactions; and inform them of appropriate use and dosage of antipyretic.

H010 OBSERVATION OF ALLERGY INJECTION PATIENT: obtain correct chart, twenty minutes post injection call patient to nurse's station, observe site of injection, observe respiratory status, record negative or positive reaction, inform patient of any follow up and time of next injection.

H011 OBSERVATION OF ALLERGY PANEL PATIENT: obtain correct chart, 20 minutes post injection; observe site of scratch tests and intradermal injections; observe respiratory status; record negative or positive reaction (in mm); instruct patient of follow up.

H012 OVERSEAS IMMUNIZATION SCREENING: obtain medical record and immunization record from patient, note location of overseas duty; note immunizations needed for locale and dates of prior immunizations; administer any needed immunizations or schedule time when the immunization may be obtained; instruct patient on needs if traveling in other countries.

H014 PULMONARY FUNCTION TEST: position patient for comfort; explain testing procedure; administer test, record results.

H015 READING SKIN TEST(S): question patient for return time of 48 or 72 hours, observe correct forearm, measure any induration with millimeter ruler, record results, instruct patient regarding any follow up.

H016 SCHOOL PHYSICAL IMMUNIZATION SCREENING: obtain medical record and immunization record from parent or guardian; note age of child and date of prior immunizations; administer any needed immunizations; document in chart and immunization record; transcribe immunization data onto physical exam form.

H017 TUBERCULIN SKIN TEST, PRICK: determine need for TB test; prepare skin test; prepare skin and administer prick TB test; instruct patient on follow up.

H018 TUBERCULIN SKIN TEST (PRICK) AND IMMUNIZATION INJECTION/ORAL: See H005 and H016

CODE

H019 TUBERCULIN SKIN TEST, INTRADERMAL (PPD): determine need for TB test; prepare skin and administer PPD; instruct patient on follow up.

M000 - OBSTETRIC-GYNECOLOGY

CODE

M001 ANNIOCENTESIS: explain procedure to patient. Obtain written consent from patient. Assist patient to supine or semi-recumbent position. obtain baseline maternal and fetal vital signs. Assist physician as needed, maintaining aseptic technique. Collect specimens and send to laboratory. (S 2424 r).

M002 CHILDBIRTH EDUCATION CLASSES: available to pregnant patients registered in the OB Clinic. Includes:
Six-week Prepared Childbirth Education Course
Refresher Course
Cesarian Preparation Class
Labor, Delivery and Nursery Tours - includes escorting group to the maternity floor, explaining procedures, criteria and equipment used, and answering questions.

M019 CULDOCENTESIS: (See E019).

M010 GYNECOLOGIC PROCEDURE, ASSIST: instruct patient; obtain consent, position patient; assist provider; label specimens.

M003 INITIAL OB VISIT INTERVIEW, INDIVIDUAL: a formal individual orientation attended by all OB patients during their first trimester. Coordinated by an RN, it is designed to assess medical and nursing history, complete lab paperwork and provide information and education, enabling patients to make sound, logical decisions about their prenatal course. The OB record is opened and labwork ordered and prescribed medications given (e.g., Iron).

M009 INITIAL OB VISIT "INTERVIEW"/GROUP CONFERENCE:

M004 NIPPLE STIMULATION CONTRACTION TEST: set patient up as for a non-stress test. Explain procedure to patient and husband/responsible party, if present. Apply warm wet towels to the patient's breats for a 5-10 minute period. Obtain baseline for FHT's and uterine baseline for contractions. Begin the test, monitoring intermittently for three FHR accelerations in response to three spontaneously induced uterine contractions within a ten minute period. Contact medical officer when test is ready for interpretation. When test is completed, detach patient from monitor.

CODE

M005 NON-STRESS TEST: explain procedure to patient. Prepare & position patient & equipment. Turn on fetal monitor, recording patient's name, date, time and reason for test. Instruct patient to depress test button when she experiences fetal movement. Monitor the fetal heart rate's response to fetal movement. Contact medical officer when test is ready for final interpretation. Detach patient from monitor. (S 2422 r)

M006 OXYTOCIN CHALLENGE TEST: explain procedure to patient and offer emotional support. Obtain written consent. prepare & position patient and equipment. record baseline measurements of any contractions, fetal movement and fetal heart rate. if no spontaneous contractions occur, start IV solution with Pitocin piggy-backed, (as ordered by physician), continuing to monitor FHR response to Pitocin-induced contractions. monitor maternal vital signs every fifteen minutes during the procedure. contact medical officer when test is ready for interpretation. when test is completed, detach patient from monitor. (S 2421 r)

M007 ULTRASOUND: prepare patient, instruct patient; carry out an invasive sound wave procedure visualizing fetus.

M008 ULTRASOUND, BIOPHYSICAL PROFILE: see M007

Q000 - ORTHOPEDICS

Definitions are understood to include patient instructions, positioning, and various applications of wraps/braces/casts unless otherwise noted.

CODE

Q001 ACE WRAP:

Q050 ARM SPLINT:

Q002 ARTHROCENTESIS: assist with needle aspiration of joint space

Q003 ARTHROSCOPY: assist with exam of joint under local anesthetic

Q004 BRACE, KNEE: velcro strap brace to knee (Don Joy)

Q005 BRACE, ROM: velcro strap long leg brace to limit range of motion

Q006 CARPAL TUNNEL RELEASE: witness consent, instruct and prep patient; assist as needed; monitor patient during procedure on median nerve (wrist); observe response and status of patient.

Q065 CAST-BRACE, LEG: apply cast and hinge hardware to leg; instruct patient

Q007 CAST, CYLINDER: cast ankle to groin to immobilize knee

Q008 CAST, DOUBLE HIP SPICA: post surgical immobilization of hips

Q009 CAST, 1½ HIP SPICA: post-surgical immobilization of one hip

Q010 CAST, GAUNTLET: short arm cast wrist immobilizer

Q011 CAST, KNEE HINGE: cast brace

Q012 CAST, LONG ARM: hand to shoulder cast

Q013 CAST, LONG ARM THUMB SPICA: hand to axilla cast with thumb immobilized.

Q014 CAST, LONG LEG NON-WEIGHT BEARING: hip to toe cast without reinforced foot.

Q015 CAST, LONG LEG WALKER: hip to toe cast with reinforced foot.

Q016 CAST, PATELLAR TENDON BEARING (LOWER LEG): short leg cast with orthotic to relieve weight bearing on lower leg.

Q057 CAST REINFORCE: apply plaster to worn section of cast.

CODE

Q017 CAST, REMOVAL: removal of plaster/fiberglass cast with cast saw and cast spreader.

Q018 CAST, REMOVAL AND X-RAY: x-ray after cast removal

Q019 CAST, SCOLIOSIS/BODY JACKET: spinal cast

Q020 CAST, SHOE/BOOT: protective shoe for cast

Q021 CAST, SHORT ARM: below elbow to hand cast excluding digits

Q022 CAST, SHORT ARM WITH OUT-RIGGER: below elbow to hand cast with metal splints to immobilize digits.

Q023 CAST, SHORT LEG NON-WEIGHT BEARING: knee to toes cast

Q024 CAST, SHORT LEG WALKER: knee to toes cast with reinforced foot

Q025 CAST, SPLINT, KNEE IMMOBILIZER: immobilize knee

Q026 CAST, SPLINT, POSTERIOR LEG: groin to ankle, may include foot.

Q027 CAST, SPLINT, RADIAL GUTTER: immobilize thumb and radius.

Q028 CAST, SPLINT, SUGAR TONGS: anterior and posterior arm spint.

Q029 CAST, SPLINT, ULNAR GUTTER: elbow to fifth digit splint

Q030 CAST, SPLINT, VOLAR: anterior forearm to hand crease.

Q031 CAST, THUMB SPICA: below elbow to hand including first digit

Q032 CERVICAL COLLAR: velcro strap appropriate size collar to neck

Q033 CLAVICLE STRAP: figure-eight strap to immobilize clavicles

Q034 CLOSED FRACTURE REDUCTION: witness consent, instruct and prep patient; assist as needed; monitor patient during procedure; observe response and status of patient.

Q035 De QUERVAIN'S RELEASE: witness consent, instruct and prep patient; assist as needed; monitor patient during procedure; observe response and status of patient.

Q507/8 DRESSING, CHANGE: see X507, X508

Q036 DRESSING, IMMOBILIZER (JONES): immobilize extremity with bulk, cotton and web roll.

CODE

Q037 INCISION AND DRAINAGE: see E047

Q038 LUMBOSACRAL (L-S) SUPPORT: velcro strap corset to torso

Q058 ORTHOPEDIC POST-OP EXAMINATION ASSISTANCE: assist physician with a routine post-operative clinic visit.

Q039 PAVLIK HARNESS: velcro strap hip splint to newborn with congenital hip dysplasia.

Q040 PIN/WIRE INSERTION: witness consent; instruct and prep patient; assist as needed; monitor patient during procedure; observe response and status of patient.

Q041 PIN/WIRE REMOVAL: see Q040.

Q042 PODIATRY, MINOR PROCEDURES, EXOSTOSES: witness consent, instruct and prep patient; assist as needed; monitor patient after foot/ankle procedure.

Q043 PODIATRY, MINOR PROCEDURES, HALLUX VALGUS: see Q042.

Q044 PODIATRY, MINOR PROCEDURES, HAMMER TOE SURGERY: see Q042.

Q045 PODIATRY, MINOR PROCEDURES, METATARSAL OSTEOTOMIES: see Q042.

Q046 PODIATRY, MINOR PROCEDURES, RESECTION ACCESSORY NAVICULAR: see Q042.

Q064 POSTERIOR LEG SPLINT (NON-CAST):

Q047 RELEASE FLEXION CONTRACTURES OF THE DIGITS: witness consent, instruct and prep patient; assist as needed; monitor patient after procedure.

Q048 REMOVAL, FIBROMA/LIPOMA/NEUROMA/SMALL MASS/CYST: see Q047.

Q049 REMOVAL OF FOREIGN BODY/SURGICAL DEVICE/RETAINED HARDWARE: see Q047.

Q050 RESECTION OF SOFT TISSUE MASS IN HAND OR FINGER: see Q047.

Q051 REVISION AMPUTATED FINGER TIP (UNCOMPLICATED): see Q047.

Q052 SLING: immobilize and support arm or shoulder.

CODE

Q058 SPLINT, ARM:

0053 SPLINT, FINGER: immobilize digit with aluminum/plastic splint.

Q064 SPLINT, LEG, NON-CAST:

Q059 SPLINT, REPAD AND REAPPLY: repad worn splint.

Q054 SPLINT, TENNIS ELBOW: apply rubberized velcro loop around forearm

Q055 TENDON LACERATION REPAIR: see Q047.

Q060 TOENAIL, REMOVAL:

Q056 Z-PLASTY ON FINGER: see Q047.

S000 - PEDIATRICS

CODE

S001 HEARING SCREEN (AUDIO BOOTH): explain test to child, allow short trial to ensure child understands directions, perform actual test, document results.

S006 IMMUNIZATION, INJECTION/ORAL:

S002 SCHOOL/SPORTS PHYSICALS: Obtain school physical form and chart, insure lab work results are on chart, obtain height, weight, BP on child, do immunization screening, visual acuity test, record all information in chart as well as on school physical form, show child and parent to exam room.

S003 TYMPANOGRAM: explain procedure to child, position child, place electroacoustic impedance bridge, provide emotional support while recording in progress.

S004 WELL BABY CHECK: weigh, measure, record; assess parent's knowledge of how to take temperature; assess general health; answer parent's questions.

X000 - SURGERY (GENERAL,PLASTIC)

CODE

X001 COLON - RECTAL EXAM (COLONOSCOPY): prep patient (procto exams require prep 2 fleets, if not done by pt prior to coming to clinic must be done in clinc prior to exam); diaper/gown/position patient, standby; assist in exam; clean room and exam instruments. See F001.

X002 ENDOSCOPIES: schedule procedure; pre-op, intra-op, and post-op teaching; obtain "Golytely" prescription and take to pharmacy; prepare operative paperwork, consent, nursing notes, op report, position and diaper patient; start IV line; prepare and administer medications as required for sedation (IV push); oper and/or prepare necessary supplies, instruments and equipment, circulate; monitor patient during procedure (BP and P q 5 min) (1:1); administer medication as required, prepare pack specimens, (1) label cup, (2) prepare tissue report, (3) log-in path log, (4) tranport specimen to path lab; recover patient in recovery room (1:1); provide postsedation instructions; provide postop instructions; clean procedures room and guerney. (see F005)

X003 MINOR SURGICAL PROCEDURES: schedule procedure; do pre-op, intra-op, and post op-teaching; prepare operative paperwork, consent, nurse notes, op report; position patient on OR table; open and/or prepare necessary supplies, instruments and equipments; prepare operation area; circulate; monitor patient during procedure (BP & P q 5 min) (1:1); prepare path specimens: (1) label cup, (2) prepare tissue, (3) log-in path log, (4) transport specimen to path lab; provide patient with follow-up apppointment and post op instructions; clean OR room and guerney; return used OR sets to CPD.

X004 PERIPHERAL VASCULAR EXAM: pulse, BP (both arms), weight; pull PV chart; perform pressure reading (plethysmography); remove and reapply Unna boots.

X005 UNNA BOOT APPLICATION: apply medication and then ace wrap to foot (feet).

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APPENDIX A

The Sherrod Code identified at the end of the ambulatory care operational definitions (S xxxx) corresponds to activities previously defined in the Nursing Care Hour Standards Study (Sherrod, Rauch, & Twist, 1981). The letter "r" by this number code (S xxxx r) denotes a similar patient care activity title but a change or revision in definition.

The operational definitions in ambulatory care services will include many patient care activities that are timed in the Sherrod study. The operational definitions in the inpatient nursing care hours study were used to time nursing care activities that were "carried out in the presence of the patient" (Sherrod, 1981, p. 4). The code is referenced to allow comparisons between the data. However, the direct patient care activities timed in the ambulatory care services will not be confined to those aspects of direct care activities carried out in the presence of a patient. Times for patient care activities will be recorded on a laptop computer so that the activity time will document the preliminary paperwork, the preparation of medications, supplies, and equipment, the procedure itself, the documentation of the procedure, and cleanup of care site and materials.

x100 LOG IN/OUT

x200 WEIGHTS/MEASURES

x227 Temp - axillary, electronic/mercury
x228 Temp - oral, electronic/mercury
x236 Temp-(oral), pulse, respirations, BP, ambulatory weight
x237 Temp-(rectal), pulse, respirations, infant weight
x229 Temp - rectal electronic/mercury
x230 Tilts/orthostatic vital signs
x231 Visual acuity
x232 Weight, Urine dipstick and BP (manual/automated)
x233 Weight(standing), height, BP (manual/automated), pediatric
x234 Weight (standing), BP (manual/automated)
x235 Weight, height, adult

x300 - ASSESSMENT

x301
x323 Assessment of skin/hair condition/infection
x302 Bowel sound assessment
x303 Cardiac assessment
x304 Clinic exit interview
x305 Clinic intake interview
x306 Corneal exam
x307 Crying patient
x308 Family advocacy interview
x309 Formalized patient contact complaint
x310 Gastrointestinal assessment
x311 Infant pulmonary assessment
x312 Mental alertness
x313 Motor/sensory testing
x314 Neurovascular check
x315 Nursing history (complete)
x316 Orientation
x317 Pt/sig. other support (crying pt)
x318 Ped growth and dev. assessment
x324 Physical exam, musculoskeletal
x319 Pulmonary assessment
x320 Pupil reflexes
x321 Sensory deficient patient support
x322 Vaginal bleeding assessment

x400 - TRANSPORT/SAFETY

x401 Adjusting restraint
x413 Assist to bathroom (on unit)
x402 Body restraint (application)
x403 Commerical leather restraint application, 2 point
x404 Commercial leather restraint application 4 point
x405 Placing infant on papoose board
x406 Securing child in mummy device

x407 Transfer - ambulance stretcher to gurney/exam table
x408 Tranfer - vehicle/chair/toilet to wheelchair
x409 Transfer - stretcher to wheelchair
x410 Tranfer wheelchair to stretcher
x411 Wrist or ankle restraint (non-commerical)

x500 - GENERAL PROCEDURES/TREATMENTS

x501 Assisting patient with rectal exam
x502 Collect valuables/personal effects
x503 Condom catheter application
x547 Crutchwalking fitting/instruction
x504 Debridgement, lg wound
x505 Debridgement, sm wound
x506 Diaper change
x507 Drg change, lg (over 4 x 5")
x508 Drg change, sm (less than 4 x 5")
x510 Dressing, reinforcement
x511 Dressing, wet sterile
x546 Enema/fleets
x512 Fluid
x513 Foley catheterization
x514 Foley catheter removal
x515 Giving a bedpan
x516 Giving a urinal
x517 Hot compress
x518 Ice pack
x519 Incontinent care
x520 Irrigation, ear - adult
x521 Irrigation, ear - pediatric
x522 Irrigation, eye
x523 Irrigation, wound
x524 Nasogastric tube - insertion
x525 Nasogastric tube - irrigation
x526 Nasogastric lavage (insert, irrigate)
x527 Nasogastric tube - removal
x528 Observation
x529 Occupied bed linen change
x530 Patch eye
x531 Positioning/adjusting side rail
x532 Positioning for X-ray
x533 Positive LP tap patient
x551 Precautions (isolation), goggles, mask and/or gloves
x534 Skin care
x535 Soak/remove from soak, hand/foot
x536 Standby, physical exam
x537 Standby pelvic
x549 Strain urine
x538 Suctioning with bulb syringe

x539 Surgical Prep, local
x540 Suture/Skin Clip Removal, 15
x541 Suture/Skin Clip Removal, 15
x542 Suture Wound, less than 15 sutures
x543 Suture wound, more than 15 sutures
x544 Undress patient/remove clothing
x545 Warm soak
x550 Wound, re-pack

x600 - INSTRUCTION/EDUCATION

x601 Answer patient question
x602 Explanation of procedures/test, witness consent
x621 Post-op instruction
x603 Teaching, blowbottles/incentive spirometer
x604 Teaching, chemotherapy instruction
x605 Teaching, colostomy care
x606 Teaching, diabetic
x607 Teaching, diagnostic test
x608 Teaching, diet/nutrition explanation
x609 Teaching, disease/condition related
x610 Teaching, dressing change
x611 Teaching, ileostomy/ileoconduit care
x612 Teaching, insulin administration
x613 Teaching, physical fitness instruct.
x614 Teaching, postural drainage
x615 Teaching, preoperative instruction
x616 Teaching, self-med administration
x617 Teaching, urine clean catch
x618 Teaching, urine testing
x619 Updating family/patient on condition
x620 Visit with pt/purposeful interaction

x700 - DIAGNOSTIC TESTS

x701 Arterial puncture - blood gases
x702 Blood sample, Dextrostix
x703 Blood sample, lancet -ear/finger/heel
x740 Breathalyzer
x704 Cardiac monitoring
x705 Culture, nose
x706 Culture, sputum
x707 Culture, throat
x735 Culture, wound
x708 ECG, CAPOC
x709 ECG, CAPOC linked to modem
x720 ECG, rhythm strip-monitor
x710 ECG, 12 lead
x711 Fecal sample collection

x712 Hematocrit
x713 Hemoccult or/guaiac testing, feces/vomitus/GI drainage
x737 Holter monitor application
x741 Holter pump application
x714 Legal alcohol/drug screen
x715 Lumbar puncture
x716 Monitor leads application/exchange
x717 Pathology specimens
x718 PKU heel sticks
x719 Pregnancy test
x739 Rapid Throat Culture (strep) test
x721 School physical exam lab work
x722 Septic work up portocol
x723 Stand-by for vag/pelvic exam
x724 Straight catheterization
x725 Theyer-Martin cultures, male
x738 Treadmill (stress test)
x726 Urine collection bag - application
x727 Urine collection bag - removal
x728 Urine dip and spin
x729 Urine dip/chemstrip
x730 Urine spec. gravity (index refractometer)
x731 Urine spec. gravity (Urinometer)
x736 Urine specimen collection (routine), assist
x732 Venipuncture - blood culture
x733 Venipuncture - blood samples
x734 Venipuncture - pediatric

x800 - MEDICATIONS/IV THERAPY

x801 Assist with IV insertion - small child
x802 Assisting and monitoring child receiving blood products
x803 Assisting and monitoring child receiving in chemotherapy
x804 Assisting and monitoring child receiving intrathecal medication
x805 Eye care
x806 Instillation of drops, ear
x807 Instillation of drops, eye
x808 Instillation of drops, nose
x809 Intra-muscular, narcotic
x810 Intra-muscular, non-narcotic
x830 Intrathecal med
x811 Intravenous infusion - blood or blood products
x812 Intravenous infusion - change IV bag/bottle
x829 Intravenous infusion - check/fix
x813 IV infusion -flow rate
x814 IV infusion - infusion pump set-up
x815 IV infusion - initiating
x816 IV infusion - IV push med
x817 IV infusion - piggyback medication

x818 IV insertion/scalp vein
x819 IV line - termination
x820 Nebulizer treatment, adult
x821 Nebulizer treatment, peciatric
x822 Oral or per NG tube
x823 Subcutaneous injection
x824 SQ infiltration by xylocaine
x825 Sublingual
x826 Suppository, rectal/vaginal
x828 Throat spray
x827 Topical

x900 - EMERGENCY PROCEDURES

x901 Airway insertion
x902 Cardiopulmonary resuscitation
x903 Nosebleed management
x904 Resiratory resuscitation, ambu
x905 Seizure care

E000 - ER, GENERAL

E001 Body temperature regulation, hypothermia:
E002 Death care:
E003 Fowlers/trendelenburg position:
E004 Isolation, gowning and gloving:
E005 Ring cutting:
E006 Seizure precautions:
E007 Thermal blanket:

E000 - ER, CARDIAC

E008 Adjusting cardiac monitor/connection leads/reset alarm:
E009 Cardioversion/defibrillation:
E010 Central venous line placement:
E011 External pacemaker:
E012 Hickman/broviac catheter (central venous access):
E013 Intravenous cutdown:
E014 Mast suit application/removal:
E015 Mediport (central venous access):
E016 Rhythm strip measurement:
E017 Rotating tourniquets, automated:
E018 Rotating tourniquets, manual:

E000 - ER, GYN

E019 Culdocentesis:
E020 Emergency delivery:
E021 Sexual assault protocol to collect legal specimens:

E000 - ER, NP

E022 Suicide precautions:

E000 - ER, PULMONARY

E023 Chest pulmonary therapy with postural drainage:
E024 Chest tube, insertion:
E025 Chest tube, removal:
E026 Cough and deep breathe:
E027 Extubation:
E028 Incentive spirometer:
E029 Intubation
E030 Oxygen administration, mask:
E031 Oxygen administration, prongs:
E032 Respiratory resuscitation, respirator:
E033 Suctioning, endotracheal:
E034 Suctioning, naso-tracheal:
E035 Suctioning, oral:
E036 Suctioning, tracheostomy:
E037 Tracheostomy, changing tube:
E038 Tracheostomy, cleaning cannula:
E039 Tracheostomy, dressing change:
E040 Thoracentesis:

E000 - ER, TRAUMA

E041 Child abuse:
E042 Debridement (burn) procedure:
E043 Decubitus care:
E044 Extremity soft tissue injury care
E045 Foreign body removal:
E051 Glasgow coma scale
E046 Head/neck trauma protocol:
E047 Incision and drainage small abscess:
E048 Needlestick protocol:
E049 Spouse abuse:
E050 Subungal hematoma release:

F000 - GASTROENTEROLOGY

F001 Colonoscopy:
F002 Colostomy dressing change:
F003 Colostomy irrigation:
F004 Diagnostic laparoscopy:
F005 Endoscopy:
F006 Enema - cleansing:
F007 ERCP - Endoscopic retrograde choleangio pancreatograph:
F008 ERCP with sphincterotomy:

F009 Fecal impaction assessment/removal:
F010 Ileostomy/ileoconduit - dressing change:
F011 Liver biopsy:
F012 Nasogastic tube - instillation:
F013 Paracentesis:
F014 Percutaneous endoscopic gastrostomy (PEG):
F015 Sigmoidoscopy/proctoscopy:

H000 - IMMUNIZATION/ALLERGY

H001 Active duty immunization screening:
H002 Allergy injection:
H003 Allergy skin testing:
H004 Anergen skin testing:
H005 Immunization injection:
H006 Immunization, injection and oral:
H007 Immunization, oral:
H008 Immunization consent form teaching:
H009 Inhalers:
H013 Instruction regarding immunization side effects:
H010 Observation of allergy injection patient
H011 Observation of allergy panel patient:
H012 Overseas immunization screening:
H014 Pulmonary function test:
H015 Reading skin test(s):
H016 School physical immunization screening:
H017 Tuberculin skin test, prick:
H018 Tuberculin skin prick & vaccine
H019 Tuberculin skin test, intradermal (PPD):

M000 - OBSTETRIC-GYNECOLOGY

M001 Amniocentesis:
M002 Childbirth education classes:
M019 Culdocentesis:
M010 Gynecologic procedure, assist
M003 Initial ob visit interview, individual:
M009 Initial ob visit "interview"/group conference:
M004 Nipple stimulation contraction test:
M005 Non-stress test:
M006 Oxytocin challenge test:
M007 Ultrasound
M008 Ultrasound, biophysical profile

Q000 - ORTHOPEDICS

Q001 Ace wrap:
Q050 Arm splint:
Q002 Arthrocentesis:

Q003 Arthroscopy:
Q004 Brace, knee:
Q005 Brace, rom:
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Q049 Removal of foreign body/surg device/retained hardware
Q050 Resection of soft tissue mass in hand or finger:
Q051 Revision amputated finger tip (uncomplicated):
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